POSITION OF THE BOARD OF NURSING ON TELEPHONE TRIAGE

In certain clinic settings, RN's and LPN's are performing telephone triage. This practice involves providing guidance to clients who call the clinic regarding health problems or symptoms, which concern them. The advice given by the triage nurse may relate to coming to the clinic, remaining at home and monitoring symptoms, or following a treatment regimen approved by the health care provider.

It is the position of the Board of Nursing that nurses performing telephone triage should be acting according to mutually accepted protocols with a physician, dentist, podiatrist, or optometrist. The board has taken the position that the act of medical diagnosis itself cannot be performed by a nurse as a delegated medical act. The advice or information provided by the triage nurse should not involve medical diagnosis, but should follow the protocols or standing orders of the physician, dentist, podiatrist, or optometrist.

Under sec. 441.11(4), Stats., and sec. N 6.03(1)(a), Code, the function of assessment is performed by the RN. Under sec. N 6.04(1)(e), Code, the LPN may assist with the collection of the data. The board has taken the position that the functions of assessment and evaluation cannot be delegated by the RN to the LPN. Accordingly, LPN's performing telephone triage must do so only in an assistive capacity under the supervision of the RN, physician, dentist, podiatrist, or optometrist.

The board recommends that the triage nurse provide callers with information regarding all options for treatment, including coming into the clinic, going to the nearest hospital or calling 911. In addition, the board recommends that the triage nurse document and name specifically which protocols or standing orders are used in providing guidance to the client based on the information gathered from the caller. The board also recommends documenting the response of the caller to the information provided.

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